		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039818

Facility Name: Jeffersonian Care Center

Address: 1700 White Street (Number) Mt. Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 242-4075 **Fax #** (618) 242-4092

IDPA ID Number: 391516877003

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT		[ ]	PROPRIETARY		[ ]	GOVERNMENTAL
	[X]	Charitable Corp.		[ ]	Individual		[ ] State
	[ ]	Trust		[ ]	Partnership		[ ] County
IRS Exemption Code	501(c)(3)			[ ]	Corporation		[ ] Other
				[ ]	"Sub-S" Corp.		
				[ ]	Limited Liability Co.		
				[ ]	Trust		
				[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	65	Skilled (SNF)	65	23,725	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,687	6,649	3,001	18,337	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,687	6,649	3,001	18,337	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.29%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,001

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	85,946	6,450	6,326	98,722		98,722		98,722			1
2	Food Purchase		83,512		83,512		83,512	(14,564)	68,948			2
3	Housekeeping	52,394	8,691		61,085		61,085		61,085			3
4	Laundry	28,916	6,766		35,682		35,682		35,682			4
5	Heat and Other Utilities			59,685	59,685		59,685		59,685			5
6	Maintenance	21,222		19,799	41,021		41,021	261	41,282			6
7	Other (specify):*											7
8	**TOTAL General Services**	188,478	105,419	85,810	379,707		379,707	(14,303)	365,404			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	827,216	76,413	2,057	905,686		905,686		905,686			10
10a	Therapy			490,808	490,808		490,808		490,808			10a
11	Activities	21,974	2,175	2,219	26,368		26,368		26,368			11
12	Social Services	14,893		1,968	16,861		16,861		16,861			12
13	Nurse Aide Training											13
14	Program Transportation			2,526	2,526		2,526		2,526			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	864,083	78,588	505,578	1,448,249		1,448,249		1,448,249			16
	C. General Administration											
17	Administrative	39,087		237,300	276,387		276,387		276,387			17
18	Directors Fees							9,293	9,293			18
19	Professional Services			1,133	1,133		1,133	30,386	31,519			19
20	Dues, Fees, Subscriptions & Promotions			7,070	7,070		7,070	291	7,361			20
21	Clerical & General Office Expenses	53,190	6,190	33,036	92,416		92,416	(1,687)	90,729			21
22	Employee Benefits & Payroll Taxes			123,344	123,344		123,344	74,334	197,678			22
23	Inservice Training & Education			53	53		53		53			23
24	Travel and Seminar			4,710	4,710		4,710	1,282	5,992			24
25	Other Admin. Staff Transportation			274	274		274	1,027	1,301			25
26	Insurance-Prop.Liab.Malpractice							38,703	38,703			26
27	Other (specify):*											27
28	**TOTAL General Administration**	92,277	6,190	406,920	505,387		505,387	153,629	659,016			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,144,838	190,197	998,308	2,333,343		2,333,343	139,326	2,472,669			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jeffersonian Care Center #0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			7,901	7,901		7,901	76,364	84,265			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,127	7,127		7,127	171,869	178,996			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			260,553	260,553		260,553	(260,553)				34
35	Rent-Equipment & Vehicles			3,469	3,469		3,469	43	3,512			35
36	Other (specify):* **Insurance - MIP**							9,925	9,925			36
37	**TOTAL Ownership**			279,050	279,050		279,050	(2,352)	276,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,765	10,781	103,546		103,546	1,804	105,350			39
40	Barber and Beauty Shops			14	14		14		14			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):* **Nonallowable Costs**			156,637	156,637		156,637	(156,637)				43
44	**TOTAL Special Cost Centers**		92,765	203,020	295,785		295,785	(154,833)	140,952			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,144,838	282,962	1,480,378	2,908,178		2,908,178	(17,859)	2,890,319			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(261)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,276	30		9
10	Interest and Other Investment Income	(4,681)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,220)	43		18
19	Entertainment				19
20	Contributions	(828)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,527)	43		24
25	Fund Raising, Advertising and Promotional	(550)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,320)	43		28
29	Other-Attach Schedule Miscellaneous Income Offset	(3,667)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (161,778)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	143,919		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 143,919		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (17,859)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Jeffersonian Care Center

ID# 0039818

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jeffersonian Care Center # 0039818 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	261	0	0	0	0	0	0	0	0	0	261	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	261	0	0	0	0	0	0	0	0	0	261	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	3,872	5,421	0	0	0	0	0	0	0	0	9,293	18
19	Professional Services	0	9,566	12,841	7,979	0	0	0	0	0	0	0	30,386	19
20	Fees, Subscriptions & Promotions	0	62	93	136	0	0	0	0	0	0	0	291	20
21	Clerical & General Office Expenses	0	487	1,468	25	0	0	0	0	0	0	0	1,980	21
22	Employee Benefits & Payroll Taxes	0	0	59,770	0	0	0	0	0	0	0	0	59,770	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	254	1,028	0	0	0	0	0	0	0	0	1,282	24
25	Other Admin. Staff Transportation	0	1,027	0	0	0	0	0	0	0	0	0	1,027	25
26	Insurance-Prop.Liab.Malpractice	0	155	100	38,448	0	0	0	0	0	0	0	38,703	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	15,423	80,721	46,588	0	0	0	0	0	0	0	142,732	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	15,684	80,721	46,588	0	0	0	0	0	0	0	142,993	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jeffersonian Care Center # 0039818 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,276	1,052	0	72,036	0	0	0	0	0	0	0	76,364	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,681)	1,172	906	174,472	0	0	0	0	0	0	0	171,869	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(260,553)	0	0	0	0	0	0	0	(260,553)	34
35	Rent-Equipment & Vehicles	0	43	0	0	0	0	0	0	0	0	0	43	35
36	Other (specify):*	0	0	0	9,925	0	0	0	0	0	0	0	9,925	36
37	**TOTAL Ownership**	(1,405)	2,267	906	(4,120)	0	0	0	0	0	0	0	(2,352)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	1,804	0	0	0	0	0	0	0	0	0	1,804	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(156,706)	0	0	69	0	0	0	0	0	0	0	(156,637)	43
44	**TOTAL Special Cost Centers**	(156,706)	1,804	0	69	0	0	0	0	0	0	0	(154,833)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(158,111)	19,755	81,627	42,537	0	0	0	0	0	0	0	(14,192)	45

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc. -	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		
See attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 261	$ 261	1
2	V	18	Board fees		Center for Residential Management, Inc.	**	3,872	3,872	2
3	V	19	Professional fees		Center for Residential Management, Inc.	**	9,566	9,566	3
4	V	20	Licenses, dues, & subs		Center for Residential Management, Inc.	**	62	62	4
5	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	487	487	5
6	V	24	Travel & seminar		Center for Residential Management, Inc.	**	254	254	6
7	V	25	Vehicle expense		Center for Residential Management, Inc.	**	1,027	1,027	7
8	V	26	Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	155	155	8
9	V	30	Depreciation		Center for Residential Management, Inc.	**	1,052	1,052	9
10	V	32	Interest expense		Center for Residential Management, Inc.	**	1,172	1,172	10
11	V	35	Vehicle lease		Center for Residential Management, Inc.	**	43	43	11
12	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	1,804	1,804	12
13	V								13
14	Total			$			$ 19,755	$ * 19,755	14

** Center for Residential Management, Inc. is Caravilla Resident Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties **Related Party Schedule**
Page 6, Section A, Column 2, Related Nursing Homes

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties
Page 6, Section A, Column 3, Other Related Business Entities

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	Board fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 5,421	$ 5,421	15
16	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	12,841	12,841	16
17	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	93	93	17
18	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	1,468	1,468	18
19	V	22	Emp. benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	59,770	59,770	19
20	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	1,028	1,028	20
21	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	100	100	21
22	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	906	906	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 81,627	$ * 81,627	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 7,979	$ 7,979	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	136	136	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	25	25	17
18	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	38,448	38,448	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	72,036	72,036	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	174,472	174,472	20
21	V	34	Rent expense	260,553	Caravilla Charitable Corporation	**		(260,553)	21
22	V	36	MIP insurance		Caravilla Charitable Corporation	**	9,925	9,925	22
23	V	43	Penalties		Caravilla Charitable Corporation	**	69	69	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V				**Caravilla Charitable Corporation and Caravilla				28
29	V				Resident Centers, Inc. have the same parent company.				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 260,553			$ 303,090	$ * 42,537	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	12,363	2 hrs.mtg.		Board Fees	$ 1,637	L18,C8	1
2	Roger Ryan	Vice President	Board Member	None	2,315	2 hrs.mtg		Board Fees	885	L18,C8	2
3	William Armstrong	Treasurer	Board Member	None	2,315	2 hrs.mtg.		Board Fees	885	L18,C8	3
4	Kay Baker	Secretary	Board Member	None	2,315	2 hrs.mtg		Board Fees	885	L18,C8	4
5	Ronald O'Daniell	Director	Board Member	None	2,315	2 hrs.mtg		Board Fees	885	L18,C8	5
6	Merla McCloud	Recorder	Administrative	None	16,874	2 hrs.mtg		Board Fees	1,526	L18,C8	6
7	Ron Schroeder	Board Member	Board Member	None	14,759	2 hrs mtg		Board Fees	641	L18,C8	7
8	Darrell Boehne	Board Member	Board Member	None	14,759	2 hrs mtg		Board Fees	641	L18,C8	8
9	Edward Childers	Board Member	Board Member	None	14,536	2 hrs mtg		Board Fees	664	L18,C8	9
10	Orland Bauer	Board Member	Board Member	None	9,756	2 hrs mtg		Board Fees	644	L18,C8	10
11											11
12	See Attached Schedule 7A										12
13								TOTAL	$ 9,293		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SCHEDULE 7A

Board of Directors Fees

	Ron Schroeder	Darrell Boehne	Edward Childers	Bob Bauer	Cora Flota	Orland Bauer	Kay Schuman Johnson	Roger Ryan	Ronald O'Daniell	William Armstrong	Kay Baker	Merla McCloud	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	207,498	21	$ 7,680	$	23,725	$ 878	1
2	20	Licenses, dues, & subs	Bed days available	207,498	21	(100)		23,725	(11)	2
3	21	Office supplies & telephone	Bed days available	207,498	21	(861)		23,725	(98)	3
4	24	Travel & seminar	Bed days available	207,498	21	(580)		23,725	(67)	4
5	25	Vehicle expense	Bed days available	207,498	21	8,145		23,725	931	5
6	26	Vehicle, fire & liab. insurance	Bed days available	207,498	21	1,353		23,725	155	6
7	30	Depreciation	Bed days available	207,498	21	9,194		23,725	1,052	7
8	32	Interest expense	Bed days available	207,498	21	8,154		23,725	932	8
9	35	Vehicle lease	Bed days available	207,498	21	375		23,725	43	9
10	39	Ancillary service centers	Bed days available, Direct	207,498	21	13,900		23,725	1,804	10
11										11
12										12
13	6	Repairs & maintenance	Direct method						261	13
14	18	Board fees	Direct method						3,872	14
15	19	Professional fees	Direct method						8,688	15
16	20	Licenses, dues, & subs	Direct method						73	16
17	21	Office supplies & telephone	Direct method						585	17
18	24	Travel & seminar	Direct method						321	18
19	25	Vehicle expense	Direct method						96	19
20	32	Interest expense	Direct method						240	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 47,260	$		$ 19,755	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Board fees	Number of beds	235	3	$ 19,600	$	65	$ 5,421	1
2	19	Professional fees	Number of beds	235	3	46,424		65	12,841	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	335		65	93	3
4	21	Office supplies & telephone	Number of beds	235	3	5,308		65	1,468	4
5	22	Emp. benefits & payroll taxes	Number of beds, Direct	235	3	(567)		65	(208)	5
6	24	Travel & seminar	Number of beds	235	3	3,716		65	1,028	6
7	32	Interest expense	Number of beds	235	3	3,276		65	906	7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						59,978	10
11	26	Vehicle, fire & liab. insurance	Direct method						100	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 78,092	$		$ 81,627	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NCS Healthcare, Inc.		X	Hardware/software	$728.00	10/31/98	$ 29,136	$ 4,004	09/30/03	0.1429	$ 3,901	1
2	Continental Wingate		X	Purchase of facility	$55,560.00	09/19/96	7,402,500	2,054,955	10/01/31	0.0855	172,779	2
3												3
4												4
5								Amortization expense			3,512	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,288.00		$ 7,431,636	$ 2,058,959			$ 180,192	9
	B. Non-Facility Related*											
10								Finance charges			3,560	10
11								Nonallowable interest expense			(3,560)	11
12								Offset interest income			(2,128)	12
13								Parent company allocation			932	13
14	TOTAL Non-Facility Related						$	$			$ (1,196)	14
15	TOTALS (line 9+line14)						$ 7,431,636	$ 2,058,959			$ 178,996	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 9,925 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		N/A $	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jeffersonian Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039818

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,008 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	125,030	1994	$ 50,000	1
2					2
3	TOTALS	125,030		$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1994	1965	$ 1,259,750	$	40	$ 31,494	$ 31,494	$ 244,078	4
5			1998	1998	9,815		40	245	245	1,103	5
6			1999	1999	1,026		40	26	26	91	6
7											7
8											8
	Improvement Type**										
9	Tile			1995	847		15	56	56	364	9
10	Fire Alarm			1996	10,125		15	675	675	3,628	10
11	Asphalt Resurfacing			1996	14,059		15	937	937	5,036	11
12	Architecture Costs			1996	4,869		15	325	325	1,747	12
13	Heating Installation			1996	14,278		15	952	952	5,117	13
14	Flooring			1997	10,440		15	696	696	3,741	14
15	Plumbing			1997	20,029		15	1,335	1,335	7,176	15
16	Rubberized Base Board Installation			1997	3,637		15	242	242	1,301	16
17	Fire Alarm			1997	1,350		15	90	90	484	17
18	Architecture Costs			1997	1,217		15	81	81	435	18
19	Roofing			1997	15,880		15	1,059	1,059	5,692	19
20	Heating and Air Conditioning			1997	3,762		15	251	251	1,349	20
21	Windows and Patio Door Installation			1997	27,742		15	1,849	1,849	9,941	21
22	Remodeling of facility			1997	4,208		15	281	281	1,264	22
23	Shutters and Windows			1997	2,350		15	157	157	706	23
24	Roofing			1997	153		15	10	10	45	24
25	Replace Controls			1998	2,516		15	168	168	756	25
26	Flooring			1998	27,771		15	1,851	1,851	8,329	26
27	Electrical Service/Plumbing			1998	1,063		15	71	71	319	27
28	Remodeling of facility			1998	1,229		15	82	82	369	28
29	Electrical/Light Fixtures			1998	2,834		15	189	189	851	29
30	Security Control Panel			1998	665		15	44	44	198	30
31	Air Conditioners			1998	1,316		15	88	88	396	31
32	Architects Fees & Site Plan			1998	7,058		15	471	471	1,648	32
33	Landscaping			1998	1,789		15	119	119	417	33
34	Emergency Roof Repair			1999	4,600		15	307	307	1,074	34
35	Ceiling & Lighting			1999	1,777		15	118	118	413	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Painting and remodeling	1999	$ 11,749	$	15	$ 783	$ 783	$ 1,940	37
38	Tile	2000	1,404	94	15	94		141	38
39	Labor for building improvements	2000	14,189		15	946	946	1,892	39
40	Automatic transfer switch	2002	3,028	101	15	101		101	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,488,525	$ 195		$ 46,193	$ 45,998	$ 312,142	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 358,823	$ 3,133	$ 36,431	$ 33,298	5-10 years	$ 209,631	71
72	Current Year Purchases	3,888	194	194		10 years	194	72
73	Fully Depreciated Assets							73
74	Parent company allocation			1,052	1,052			74
75	TOTALS	$ 362,711	$ 3,327	$ 37,677	$ 34,350		$ 209,825	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	1997 Ford E150***	1997	$ 13,243	$	$	$	3	$ 13,243	76
77	Resident use	1998 Chevy Corsica***	2002	489	82	82		3	82	77
78	Resident use	1997 Ford Taurus***	2002	978	163	163		3	163	78
79	Resident use	1992 Chevy Van***	2002	900	150	150		3	150	79
80	TOTALS			$ 15,610	$ 395	$ 395	$		$ 13,638	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,916,846	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 3,917	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,265	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 80,348	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 535,605	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,944 Description: Dishwasher $1,209; Postage meter $672; Other equipment rental $63
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident care	1998 Chevy Corsica	$ 83.00	$ 500	17
18	Resident care	1997 Ford Taurus	108.00	650	18
19	Resident care	1992 Chevy Van	63.00	375	19
20	Parent company allocation			43	20
21	TOTAL		$ 254.00	$ 1,568	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,971	$ 193,118	$	2,971	$ 193,118	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		774	59,549		774	59,549	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,498	227,380		3,498	227,380	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				87,979		87,979	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Attached Schedule 16A				129	10,781	6,590	129	17,371	13
14	TOTAL			$	7,372	$ 490,828	$ 94,569	7,372	$ 585,397	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Jeffersonian Care Center
Provider #0039818
June 30, 2002 **Schedule 16A**

Schedule XIV - Special Services
Line 13 - Other (Specify)

Service	Schedule V Reference	Units of Service	Cost	Supplies
Part B Medicare Supplies	L39,C8			6,590
X Ray	L39,C3	Monthly	1,174	
Laboratory	L39,C3	Monthly	8,054	
Special Services	L39,C3	129	1,553	
TOTAL		129	10,781	6,590

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 31,068	$ 31,068	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 525,082)	336,695	336,695	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,141	4,141	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	8,783	8,783	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 380,687	$ 380,687	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,270,591	14
15	Leasehold Improvements, at Historical Cost	4,432	217,934	15
16	Equipment, at Historical Cost	52,104	378,321	16
17	Accumulated Depreciation (book methods)	(21,937)	(535,605)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	1,524	1,524	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,123	$ 1,382,765	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 416,810	$ 1,763,452	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 359,696	$ 359,696	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	76,575	76,575	29
30	Accrued Salaries Payable	64,787	64,787	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	30,818	30,818	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	465,339	85,366	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 997,215	$ 617,242	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,004	1,982,384	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,004	$ 1,982,384	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,001,219	$ 2,599,626	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (584,409)	$ (836,174)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 416,810	$ 1,763,452	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Jeffersonian Care Center
Provider #0039818
June 30, 2002 **Schedule 17A**

Schedule XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other Current Assets		
Prepaid Deposit	4,291	4,291
Medicare Settlement	4,492	4,492
	8,783	8,783
Line 23 - Other		
Investment in Subsidiary	1,524	1,524
Line 36 - Other Current Liabilities		
Accrued Expense	149	149
Resident Credit Balances	69,657	69,657
Accrued Rent	379,973	-
Accrued Participation Fees	9,068	9,068
Accrued Insurance Payable	6,245	6,245
Wage Assignments	247	247
	465,339	85,366

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,889)	1
2	Restatements (describe):		2
3	**Prior period audit adjustment**	(260,099)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (262,988)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(225,658)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company allocation**		15
16	Other (describe) **added back in column 7**	(95,763)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (321,421)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (584,409)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,847,453	1
2	Discounts and Allowances for all Levels	(312,697)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,534,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	944,477	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 944,477	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	370	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,708	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,831	19
20	Radiology and X-Ray	1,761	20
21	Other Medical Services	40,970	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 193,640	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,121	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,121	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	8,526	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,526	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,682,520	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	379,707	31
32	Health Care	1,448,249	32
33	General Administration	505,387	33
	B. Capital Expense		
34	Ownership	279,050	34
	C. Ancillary Expense		
35	Special Cost Centers	260,197	35
36	Provider Participation Fee	35,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,908,178	40
41	**Income before Income Taxes (line 30 minus line 40)****	(225,658)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (225,658)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,112	$ 38,418	$ 18.19	1
2	Assistant Director of Nursing	3,245	3,251	50,985	15.68	2
3	Registered Nurses	5,070	5,476	81,683	14.92	3
4	Licensed Practical Nurses	16,683	17,706	227,738	12.86	4
5	Nurse Aides & Orderlies	43,524	45,691	341,952	7.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,966	2,119	16,804	7.93	8
9	Activity Director					9
10	Activity Assistants	3,007	3,218	21,974	6.83	10
11	Social Service Workers	1,568	1,727	14,893	8.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,180	14,029	85,946	6.13	15
16	Dishwashers					16
17	Maintenance Workers	2,019	2,252	21,222	9.42	17
18	Housekeepers	8,376	9,121	52,394	5.74	18
19	Laundry	4,791	5,059	28,916	5.72	19
20	Administrator	1,601	1,609	39,087	24.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,630	5,957	53,190	8.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,693	3,090	29,785	9.64	31
32	Other Health Ca See Sch 20A	3,645	3,946	39,851	10.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,990	126,363	$ 1,144,838 *	$ 9.06	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	139	$ 6,326	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	17	958	L10, C3	37
38	Nurse Consultant	Monthly	1,004	L10, C3	38
39	Pharmacist Consultant	Monthly	95	L10, C3	39
40	Physical Therapy Consultant	646	5,169	L10A, C3	40
41	Occupational Therapy Consultant	441	3,529	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	258	2,063	L10A, C3	43
44	Activity Consultant	38	1,968	L11, C3	44
45	Social Service Consultant	38	1,968	L12, C3	45
46	Other(specify) Office Consultant	Monthly	11,737	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,577	$ 40,817		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Jeffersonian Care Center
Provider #0039818
June 30, 2002 **Schedule 20A**

Schedule XVIII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	1,732	1,900	25,868	13.61
Ancillary Clerk	1,913	2,046	13,983	6.83
	3,645	3,946	39,851	10.10

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stephen Hopkins	Administrator	0%	$ 17,934
Barbara Berndsen	Administrator	0%	21,153
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 39,087

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$ 237,300
Administrative Service Fees	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 237,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 984
Lawrence Manson	Legal	149
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,133

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,978
Unemployment Compensation Insurance	11,038
FICA Taxes	88,050
Employee Health Insurance	22,891
Employee Meals	14,564
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	1,090
Vaccinations	67
TOTAL (agree to Schedule V, line 22, col.8)	$ 197,678

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 235
Advertising: Employee Recruitment	1,914
Health Care Worker Background Check	
(Indicate # of checks performed 122)	854
Illinois Health Care Association	3,823
Various fees	337
Parent company allocation	198
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,361

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,771
Seminar Expense	4,288
Parent company allocation	(67)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,992

* Attach copy of IMRF notifications

**See instructions.

Jeffersonian Care Center
Provider #: 0039818
07/01/01 to 06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services	Type	Amount
Total (agree to Schedule V, line 19, column 3)		1,133
Allocated from Caravilla Charitable Corporation		
American Express Tax & Business Services	**Accounting**	1,828
Altschuler, Melvoin & Glasser LLP	**Accounting**	6,151
Allocated from parent company		
American Express Tax & Business Services	**Accounting**	1,619
Altschuler, Melvoin & Glasser LLP	**Accounting**	1,575
Heinold-Banwart	**Accounting**	2,755
Lawrence Manson	**Legal**	3,615
Allocated from Caravilla Resident Centers, Inc.		
American Express Tax & Business Services	**Accounting**	415
Altschuler, Melvoin & Glasser LLP	**Accounting**	9,248
Lawrence Manson	**Legal**	2,594
Crain, Miller & Associated	**Legal**	354
Carr Korein Tillery	**Legal**	232
Total (agree to Schedule V, line 19, column 8)		31,519

See Accountants' Compilation Report

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jeffersonian Care Center # 0039818 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,823**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **No**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **3,723** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **35,588**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **14,564** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **66%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit is currently in progress.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Jeffersonian Care Center** **03:15 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-17,859	equal to	-17,859	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	178,996	equal to	178,996	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	84,265	equal to	84,265	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,512	equal to	3,512	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	490,808	equal to	490,808	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	94,569	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	379,707	equal to	379,707	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,448,249	equal to	1,448,249	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	505,387	equal to	505,387	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	279,050	equal to	279,050	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	260,197	equal to	260,197	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,588	equal to	35,588	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	770,561	equal to	827,216	-56,655	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,974	equal to	21,974	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	14,893	equal to	14,893	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	85,946	equal to	85,946	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	21,222	equal to	21,222	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	52,394	equal to	52,394	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	28,916	equal to	28,916	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	39,087	equal to	39,087	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	53,190	equal to	53,190	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,144,838	equal to	1,144,838	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	6,326	< or = to	6,326	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,057	< or = to	2,057	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,968	< or = to	2,219	-251	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,968	< or = to	1,968	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	39,087	equal to	39,087	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	237,300	equal to	237,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	1,133	equal to	1,133	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	197,678	equal to	197,678	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,361	equal to	7,361	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,992	equal to	5,992	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,588	equal to	35,588	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	14,564	< or = to	74,334	-59,770	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	14,564	equal to	14,564	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,001	equal to	3,001	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	143,919	equal to	143,919	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,058,959	equal to	2,058,959	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,488,525	equal to	1,488,525	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	378,321	equal to	378,321	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	535,605	equal to	535,605	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-584,409	equal to	-584,409	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-225,658	equal to	-225,658	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	416,810	equal to	416,810	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	85,946	6,450	6,326	98,722	0	98,722	0	98,722
2. Food P	0	83,512	0	83,512	0	83,512	-14,564	68,948
3. Housek	52,394	8,691	0	61,085	0	61,085	0	61,085
4. Laundry	28,916	6,766	0	35,682	0	35,682	0	35,682
5. Heat ar	0	0	59,685	59,685	0	59,685	0	59,685
6. Mainter	21,222	0	19,799	41,021	0	41,021	261	41,282
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	188,478	105,419	85,810	379,707	0	379,707	-14,303	365,404
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	827,216	76,413	2,057	905,686	0	905,686	0	905,686
10a. Ther	0	0	490,808	490,808	0	490,808	0	490,808
11. Activit	21,974	2,175	2,219	26,368	0	26,368	0	26,368
12. Social	14,893	0	1,968	16,861	0	16,861	0	16,861
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	2,526	2,526	0	2,526	0	2,526
15. Other	0	0	0	0	0	0	0	0
16. Total H	864,083	78,588	505,578	1,448,249	0	1,448,249	0	1,448,249
17. Admin	39,087	0	237,300	276,387	0	276,387	0	276,387
18. Direct	0	0	0	0	0	0	9,293	9,293
19. Profes	0	0	1,133	1,133	0	1,133	30,386	31,519
20. Fees,	0	0	7,070	7,070	0	7,070	291	7,361
21. Clerica	53,190	6,190	33,036	92,416	0	92,416	-1,687	90,729
22. Emplo	0	0	123,344	123,344	0	123,344	74,334	197,678
23. Inserv	0	0	53	53	0	53	0	53
24. Travel	0	0	4,710	4,710	0	4,710	1,282	5,992
25. Other	0	0	274	274	0	274	1,027	1,301
26. Insura	0	0	0	0	0	0	38,703	38,703
27. Other	0	0	0	0	0	0	0	0
28. Total (	92,277	6,190	406,920	505,387	0	505,387	153,629	659,016
29. Total (	1,144,838	190,197	998,308	2,333,343	0	2,333,343	139,326	2,472,669
30. Depre	0	0	7,901	7,901	0	7,901	76,364	84,265
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	7,127	7,127	0	7,127	171,869	178,996
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	260,553	260,553	0	260,553	-260,553	0
35. Rent -	0	0	3,469	3,469	0	3,469	43	3,512
36. Other	0	0	0	0	0	0	9,925	9,925
37. Total (	0	0	279,050	279,050	0	279,050	-2,352	276,698
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	92,765	10,781	103,546	0	103,546	1,804	105,350
40. Barbe	0	0	14	14	0	14	0	14
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	35,588	35,588	0	35,588	0	35,588
43. Other	0	0	156,637	156,637	0	156,637	-156,637	0
44. Total S	0	92,765	203,020	295,785	0	295,785	-154,833	140,952
45. Grand	1,144,838	282,962	1,480,378	2,908,178	0	2,908,178	-17,859	2,890,319

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	31,068	31,068
2. Cash - F	0	0
3. Account	336,695	336,695
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	4,141	4,141
7. Other Prepaid Expenses		
8. Accounts Receivable-Owner/Related Party		
9. Other (s	8,783	8,783
10. Total c	349,869	349,869
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	50,000
14. Buildin	0	1,270,591
15. Leasel	4,432	217,934
16. Equipn	52,104	378,321
17. Accum	-21,937	-535,605
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	1,524	1,524
24. Total L	36,123	1,382,765
25. Total A	385,992	1,732,634
CURRENT LIABILITIES		
26. Accour	359,696	359,696
27. Officer'	0	0
28. Accour	0	0
29. Short-T	76,575	76,575
30. Accrue	64,787	64,787
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	30818	30818
34. Deferre	0	0
35. Federa	0	0
36. Other (	465,339	85,366
37. Other (	0	0
38. Total C	966,397	586,424
LONG TERM LIABILITES		
39.Long-Te	4,004	1,982,384
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	4,004	1,982,384
46.Total Li	970,401	2,568,808
47.Total Eo	-584,409	-836,174
48.Total Li	385,992	1,732,634

		Balance per Medicaid Trial Balance
1.	Gross F	1,847,453
2.	Discour	-312,697
	Subtota	1,534,756
4.	Day Ca	0
5.	Other C	0
6.	Therapy	944,477
7.	Oxygen	0
	Subtota	944,477
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	370
15.	Teleph	0
16.	Rental	0
17.	Sale o	138,708
18.	Sale o	0
19.	Labora	11,831
20.	Radiol	1,761
21.	Other	40,970
22.	Laund	0
	Subtot	193,640
24.	Contril	0
25.	Interes	1,121
	Subtot	1,121
27.	Other	0
28.	Other	8,526
	Subtot	8,526
30.	Total F	2,682,520
31.	Gener	680,120
32.	Health	1,154,988
33.	Gener	668,561
34.	Owner	144,710
35.	Specia	60,174
35.	Provid	41,063
37.	Other	0
40.	Total E	2,749,616
41.	Incom	-67,096
42.	Incom	0
43.	Net In	-67,096

Page

Line 16 for mortgage insurance.